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Citation for published version:

Bambra, C & Smith, K 2010, 'No longer deserving? sickness benefit reform and the politics of (ill) health', *Critical Public Health*, vol. 20, no. 1, pp. 71-83. <https://doi.org/10.1080/09581590902763265>

Digital Object Identifier (DOI):

[10.1080/09581590902763265](https://doi.org/10.1080/09581590902763265)

Link:

[Link to publication record in Edinburgh Research Explorer](#)

Document Version:

Peer reviewed version

Published In:

Critical Public Health

Publisher Rights Statement:

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Bambra, C., & Smith, K. (2010). No longer deserving? Sickness benefit reform and the politics of (ill) health. Critical Public Health, 20(1), 71-83

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No longer deserving? Sickness benefit reform and the politics of (ill) health.

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Article length: 4176 words

ABSTRACT

Income maintenance during unemployment, old age or long-term sickness is a key facet of welfare provision and an important mediatory factor in the relationship between socio-economic position and health status. Since October 2008, the main long-term sickness absence benefit in the UK (Incapacity Benefit) has been replaced with 'Employment Support Allowance'. Despite the importance of income maintenance for health and health inequalities, this change has been largely ignored within public health circles. After outlining these reforms and providing a historical policy context, this article utilises welfare reform theory and empirical literature to argue that these changes represent a broader international transformation from welfare to workfare states, the re-emergence of labour discipline, and a political shift in how people suffering from ill health are categorised as disabled or not and perceived as 'deserving' or 'undeserving' of state support. Finally, the case is made for the need to develop a new critical public health research and practice agenda around worklessness.

158 words

INTRODUCTION

*'If you think that living on welfare is all sugar, cherries and honey, you're wrong,
because there is too much month left at the end of the money'*

Welfare Rights Campaigner 1970s USA.

Income maintenance during unemployment, old age or long term sickness is the key facet of welfare provision and an important mediatory factor in the relationship between socio-economic position and health status (Eikemo and Bambra, 2008). Since October 2008, the main long term sickness absence benefit in the UK (Incapacity Benefit) has been replaced by an 'Employment Support Allowance' (ESA) (DWP, 2006; HMSO, 2006) (see Box 1). This change has been largely ignored within public health circles, despite the importance of income maintenance policies for health and health inequalities. This article outlines and contextualises these reforms, and utilises welfare reform theory and evidence to argue that they reflect a broader international transformation from welfare to workfare states, represent a re-emergence of labour discipline, and signify a political shift in how people suffering from ill health are defined as disabled or not, and perceived as 'deserving' or 'undeserving' of state support. Finally, the need for engagement by the wider public health community is emphasised and the article begins to outline what a critical public health research and practice agenda focusing upon ill health related worklessness might look like.

UK HISTORICAL POLICY CONTEXT

Historically in the UK (and elsewhere), disability and chronic illness are associated with poverty and social exclusion (Acheson et al, 1998; Bartley and Lewis, 2002; Oliver and Barnes, 1998). This is largely because work is one of the main sources of income in the UK and people with disabilities and chronic illnesses have disproportionately low employment rates. Since 1945, government action in terms of changing this situation can be categorised into three distinct phases: passive welfarism, active welfarism and what this paper suggests is a move towards 'workfare' (Box 2).

Box 1: Sickness absence benefits in the UK

Since October 2008, Incapacity Benefit (IB) will be replaced, for new but not existing claimants, by the 'Employment Support Allowance' (DWP, 2006; HMSO, 2006).

IB is the main non-means tested social security cash benefit, paid to 2.7 million people in the UK who are assessed initially by a General Practitioner (GP), and after six months by a Benefits Agency doctor, as being incapable of work due to illness or disability and who have contributed sufficient National Insurance payments. IB is similar in remit to the long-term sickness and disability insurance schemes of other Western countries, such as the USA's Social Security Disability Insurance and the disability pensions of Germany and Sweden (OECD, 2003). There are three rates of IB including two short-term rates: a lower rate which is paid for the first 28 weeks of sickness, and a higher rate for weeks 29 to 52. The third, a long-term IB rate, applies to people who have been sick for more than a year and comprises the largest number of claimants. IB can be received up to pensionable age.

The new Employment Support Allowance (ESA) will involve a two-tier system of benefits in which all are entitled to the ESA basic benefit (paid at the same rates as unemployment benefit - Job Seeker's Allowance). However, those judged (via a medically administered 'work capability' test) unable to work or with limited work capacity due to the severity of their physical or mental condition will receive a higher level of benefit (Support Allowance) with no conditionality. Those who are deemed 'sick but able to work' will only receive an additional Employment Support component if they participate in employability initiatives such as Pathways to Work (DWP, 2006; HMSO, 2006).

Box 2: 'Welfare' and 'Workfare'

'Welfare' provision is characterised by the passive and unconditional nature of benefits. Benefits are passive, as they provide a 'safety net' of cash benefits, and they are unconditional, as entitlement comes via citizenship. In contrast, 'workfare' is active, providing a 'trampoline' effect whereby receipt of cash benefits is supplemented with training and work experience. Rights to benefits under 'workfare' are, to varying degrees, conditional upon fulfilling certain obligations such as involvement in training programmes, work experience or community service. 'Workfare' is therefore defined not just as 'work for benefits' (Robinson, 1998: 87) but as any active measure which results in 'an increasing emphasis on the obligations of the workers' (Torring, 1999).

Passive approach

The first (passive) phase of public policy towards the employment of people with a disability or chronic illness was framed by the Disabled Persons Employment Act of 1944 which set up supported employment programmes (such as Remploy), medical rehabilitation services, and the post-war employment quota. In the 1970s, these measures were supplemented with a number of health related out-of-work cash benefits, such as Invalidity/Incapacity Benefit in 1971 (IB). During the social security reforms of the 1980s and early 1990s, additional restrictions were placed on these cash benefits (e.g. the introduction of the 'all work' test in 1994). However, a radical shift of policy, fuelled by growing Treasury concerns about the costs of disability related benefits (Treasury, 1998), alongside pressure from disability campaign groups in relation to social exclusion (Barnes, 1991; 2002; Danieli and Wheeler, 2006), did not occur until the mid-1990s. The Disability Discrimination Act of 1995 (and subsequent amendments) abolished the post-war disability employment quota in favour of a more rights-based approach to the employment of disabled people (Floyd and Curtis, 2000; Oliver and Barnes, 1998; Pope and Bamba, 2005; Bamba and Pope, 2007).

Active approach

Although the UK welfare state has always contained a certain element of active welfarism (for example Beveridge himself was an 'activist' and certainly many of the new post-war cash benefits such as pensions were only available to people who had previously paid national insurance contributions (Fulcher and Scott, 2003)), in more recent decades it has become more prominent and far reaching. In the second (active) phase of government action, people with a disability or long-term condition have represented a key group of working age benefit recipients and, as such, they have been the targets of a number of diverse active labour market interventions (Treasury, 2003). For example, the Disability Working Allowance (DWA), the New Deal for Disabled People (NDDP), and the Access to Work programme (ATW). These phase two interventions have generally tried to overcome the different barriers which people with a disability or chronic illness face when trying to enter employment, including: lack of experience or skills; uncertainty from employers; problems with physical access to work; and concerns over pay, hours and conditions (Gardiner, 1997; Goldstone and Meager, 2002). The majority of interventions have been supply-side focused, and participation by people in receipt of benefits has been on a voluntary basis (Bambra et al, 2005; Bambra, 2006).

Despite an increase in these kinds of intervention since the 1990s, the employment rate for people with disabilities is still very low, at around 49%, compared with 81% for those without (ONS, 2003). In 2004, there were around 2.7 million IB related recipients (Prime Ministers Strategy Unit, 2005). This has meant that people on health-related benefits have remained at the centre of the welfare reform agenda (Blair, 2002; Prime Minister's Strategy Unit, 2005), with the benefits of (re)employment for health and well-being increasingly being emphasised in policy circles (Black, 2008).

Towards 'workfare'

The replacement of IB with the two-tiered ESA (Box 1) builds on the Government's previous reforms of IB in 1999, when claims became dependent on National Insurance contributions and the Personal Capacity Test was introduced. However, the addition of such an element of conditionality for people in receipt of health related benefits is new within the UK context

(although Work Focused Interviews are a compulsory part of the 2003 Pathways to Work programme) and signals a break with the voluntary nature of previous participation in employment interventions. It is in some respects, therefore, the dawn of a third phase of UK policy towards the employment of people with a disability or chronic illness, and one which could be considered as a move towards making these recipients subject to 'workfare' (Box 2).

INSIGHTS FROM WELFARE THEORY

Adding conditionality, in the form of compulsory involvement in active labour market programmes, is novel in terms of UK sickness absence benefits. However, it is in keeping with the reform of other UK benefits (such as the reforms to unemployment benefit of the 1980s and 1990s) and changes to sickness absence benefits elsewhere, such as in Australia or the USA (Stone, 1984; OECD, 2003). These reforms are often presented as being initiated on the grounds of reintroducing recipients to the labour market or providing an incentive for people who are out of work to look for and return to work (Henning-Bjorn, 2004). However, the application of wider welfare theory provides some alternative explanations.

Welfare to workfare?

In general, these kinds of reforms, which have been taking place in a range of advanced welfare states since the 1980s, have been conceptualised as a gradual transition from a Fordist welfare capitalism, in which the welfare state and social security were characterised by centralism and universal, passive, and unconditional benefits, to a post-Fordist 'workfare' capitalism in which welfare provision is pluralist and benefits are targeted, active and conditional (Box 2) (Amin 1994; Peck 2001; Painter 2002). The academic discourse around 'workfare' has been accompanied by discussions about the recommodification of labour and the extent to which welfare remains an entitlement of citizenship (Torfing 1999; Dean 2001; Robinson 1998). There have also been debates about the extent to which welfare state development is path dependent and the extent to which core characteristics of welfare states remain entrenched, despite such changes (Torfing 1999).

The transformation of the welfare state and the shift towards welfare to work and/or workfare has also been accompanied by a shift in political language. Increasingly, there is discussion in policy and academic circles of the “underclass” (particularly in the USA) or the “socially excluded” (a more European concept), constituting the unemployed, the low skilled and other marginalised groups (Byrne, 2005). Welfare to work policy, as evident in government policy documents on the IB reform (DWP, 2006), is promoted as an “anti-exclusion” policy, a way of empowering people and re-engaging those who are “socially excluded” with the system. However, as Byrne (2005) has argued, the articulation of the concept of social exclusion within policies such as welfare to work has in practice tended to create and reinforce, rather than break down, the main exclusionary economic processes of post-industrial capitalism: the work obtained by welfare to work participants is usually poor quality, low paid and insecure (also known as the low pay, no pay cycle). Welfare to work participants therefore represent the flexible reserve labour force required by post-Fordist accumulation practices (Byrne, 2005: 1).

Reflecting the history of welfare reform, most of the analysis to date has focused on changes to unemployment related benefits and benefits associated with lone parenthood (e.g. Peck, 2001; Lodemel and Trickey, 2001; Clasen and Clegg, 2003; Byrne, 2005). Nevertheless, the conceptual framework offered by these theorists also helps explain the reform of sickness benefit in the UK, especially the advent of conditionality and the framing of the policy debate around the social inclusion of the sick and disabled.

Reasserting labour discipline?

The reforms to IB can also be conceptualised as a way of reasserting labour discipline and ensuring that work is undertaken. There are four salient aspects of the labour discipline thesis: Firstly, commentators such as Ginsburg argue that the social security benefits system disciplines the labour force by attaching conditions to benefits which ‘ensure that the intransigent worker cannot so easily turn to the welfare state for support’ (Ginsburg, 1979). This aspect of the labour discipline thesis is evident in the UK reforms as recipients of the ESA will have to take part in employability schemes in order to receive full benefits.

Secondly, following Piven and Cloward (1971), the IB reforms can be seen as part of a wider welfare state retrenchment, as welfare provision acts as a means of 'regulating the poor'. Hence, provision tends to be expanded during times of political unrest and subsequently reduced once a measure of social peace has been restored. For example the civil unrest in the USA in the 1960s was associated with a subsequent expansion of the welfare state which, once social order was restored, was followed up by a series of cutbacks under the 1980s Reagan administration. Given that the UK has recently experienced a period of relative peace, it might be expected that welfare benefits would now be cutback.

Thirdly, Katz (1986) argues that the stigma associated with benefit receipt also acts as a discipline upon the labour force, with dependency on state benefits considered not only a misfortune but a moral failure. The tiered approach of the new ESA system to claimants may heighten this aspect of labour discipline, with those deemed 'sick but able to work' feeling particularly stigmatised.

Finally, as David Byrne's work has shown (2005), the reforms to welfare provision of the last two decades in the UK and elsewhere (particularly the Clinton era USA) have not been about ending benefit dependency but about linking benefit receipt more closely to work. So for example, the Clinton administration "Earned Income tax Rebate" and "Earned Income Tax Credit" as well as the Blair/Brown "Working Family Tax Credit" or "Child Tax Credit" have increased the income of working families substantially, but only whilst they are in work - out of work cash benefits have not been increased. Similarly, as has long been argued in regard to the political economy of the welfare state (see Gough, 1979), these in-work benefits act as wage subsidies to low paying employers which are funded via horizontal redistribution within the working population rather than vertically via income redistribution and corporate taxes (Byrne, 2005: 156). The IB reforms can thus be seen as the somewhat logical extension of the use of the benefits system to assert the work ethic. The reforms similarly reinforce divisions of who is (working poor) and who is not (non-working poor) deserving of state support (see below).

No longer deserving?

The 2008 reforms to IB also need to be understood in the context of political debates about the relationship between unemployment and health (Bambra, 2008) and research into the relationship between IB receipt, health and employment (Bambra and Norman, 2006). Although, in order to qualify for IB, medical certification by a GP or benefits system doctor is required, the IB system has long been criticised as providing a means of people avoiding work, and as a mechanism which obscures unemployment levels (Beatty and Fothergill, 1999; 2002; Beatty et al., 2000; Fieldhouse and Hollywood, 1999; Fothergill, 2001). Indeed claims that disability-related welfare claims represent “welfare scrounging” are not limited to the UK (OECD, 2003). Nor are they particularly new; the American Social Security Disability Insurance, for example, was subject to similar debate and was subsequently reformed under the Reagan administration in the early 1980s (Stone, 1986). However, individual level evidence from recent cohort studies suggests that medically certified sickness absence does reflect actual morbidity and mortality (Marmot et al, 1995; Kivimaki et al., 2003; Vahtera et al, 2004), and recent population level studies found a strong relationship between IB claims and mortality (Bambra and Norman, 2006; Norman and Bambra, 2007). Nevertheless, despite the absence of any direct evidence (Bambra, 2006), a popular perception remains that IB is a disincentive to work, particularly in political and media debates about worklessness (Grieve-Smith, 2005; Wintour, 2005). This perception appears to underlie the division of conditionality for the ESA between types of health condition: those considered ‘sick but able to work’ will receive lower levels of benefit which will also be conditional, whereas those considered to have a more severe illness or disability will receive a higher rate of unconditional benefit.

The separation of health-based claims into two distinct categories is, on the one hand, a logical consequence of Blair’s ‘work for those who can, welfare for those who cannot’ approach to reform (Blair, 2002), and an acknowledgment that previous, more passive approaches have often exacerbated the labour market exclusion experienced by people with a disability or chronic illness. However, on the other hand, the division into two levels of benefits is inevitably tied into notions of the ‘deserving’ and ‘undeserving’ poor (Katz, 1989;

van Orschot, 2006). Health related cash benefits are amongst the last in the UK system to be the subject of extensive reform and, until recently, did not attract as much popular stigma as other types of benefits (most notably lone parent benefits). This is also the case in other countries, where people in receipt of benefits due to ill health or disability have been viewed and treated as more 'deserving' or morally worthy than those in receipt of other types of benefit (Stone, 1986; van Orschot, 2006).

Indeed, as Deborah Stone argued in 'The Disabled State' (1986), in many Western countries, disability was for a long time considered to be a special administrative category in the welfare state and one which came with distinctive entitlements in the form of social aid and exemptions from certain obligations of citizenship, such as the duty to work (Stone, 1986: 4). Drawing on Stone (1986), the IB reforms can be seen as a move away from such an accommodating perspective, and thereby represent the beginning of a potentially disturbing political discourse which dictates that certain types of illness or disability are less deserving of unconditional public support than others. The construction of disability has long been an important feature of the welfare state as, in addition to bestowing political privilege on those deemed disabled (Stone, 1986), it places additional obligations on those considered non-disabled. As Stone comments, the state determines what injuries, diseases, and incapacities those defined as non-disabled have to endure as part of their normal working lives (Stone, 1986: 4). In this context, it is worth considering that this deserving/undeserving dichotomy and the redrawing of the lines around what is and what is not incapacity may well reinforce and magnify the existing stigma attached to claims based on mental (as opposed to physical) illness (see Slade, McCrone and Thornicroft, 1995; Slattery, 2006).

EVIDENCE BASED POLICY?

In light of the fact it is unclear on what basis it was decided to replace IB with the new ESA system, it is worth emphasising that, since 1997, the UK government has repeatedly committed itself to being guided by research evidence about 'what works' (Blunkett, 2000; Cabinet Office, 1999, 2000; Mulgan & Lee 2001; Wanless 2004). The notion of 'evidence-based policy' has, of course, encountered a variety of problems since the early days of New

Labour and it is now widely accepted that research evidence can rarely offer clear-cut solutions to complex policy problems (Packwood 2002; Smith, 2007; Young, 2004). Indeed, within some policy quarters, the term 'evidence-based policy' has now been replaced with the less stringent notion of 'evidence-informed policy' (e.g. Department for International Development 2005). Nevertheless, official commitment to employing relevant research evidence, where it is available, remains. Hence, given that there is a wealth of evidence about the effectiveness (or otherwise) of return to work schemes for people on IB (e.g. Bambra et al, 2005; Bambra, 2006), it might be expected that decisions about reforming the existing IB system would draw upon this body of work, at least to some extent.

However, welfare reform in this policy area appears to be taking place in something of an evidence vacuum. Not only is there a lack of clarity about the evidence base for the reforms (given that there is no evidence about whether adding compulsion to such interventions will make them more successful in helping such claimants return to work) but the evidence base highlighting the questionable effectiveness of previous active labour market programmes targeted at IB claimants in the UK (e.g. Bambra et al 2005; Bambra, 2006) appears to have been ignored. Indeed, evaluations of previous employment interventions for people with a disability or health condition suggest the main problem has not been the lack of a component promoting compulsion but the supply-side focus of these programmes, especially in areas experiencing low overall demand for labour and a low-wage economy (Bambra et al, 2005; Bambra, 2006; see also Turok, 2000).

This paper is far from the first observation that policy developments under New Labour appear not to have been based on available research evidence (e.g. Naughton 2005; Smith, 2007; Stevens 2007) and it must be acknowledged that studies of the relationship between research and policy have long highlighted the complexity of the process and the vast range of actors and interests involved (e.g. Cohen, March & Olsen 1972; Kingdon, 1984, 1995; Weiss, 1977, 1979). This is not to say, however, that academics should refrain from drawing attention to apparent failures by policymakers to draw on relevant existing evidence or, where evidence itself is lacking, to the need for new research agendas to be developed. For even

Weiss' (1977, 1979) famous 'enlightenment model' of the relationship between research and policy, and Kingdon's (1984, 1995) notion of 'policy windows', suggest research evidence can play an important role in policy outcomes (albeit in unpredictable and often relatively subtle ways). It seems especially reasonable to point out gaps between policy and research in an era in which policymakers have specifically claimed research evidence will be prioritised (Boaz and Haydon, 2002).

A basic problem with the concept of 'evidence-based policy' is, of course, that the term 'evidence' can itself be interpreted in starkly contrasting ways by different actors (Davies *et al.* 2000; McQueen & Anderson 2003; Young *et al.* 2002). It may be the case that the reforms to IB have been influenced by the government's experience of previous reforms, or by observations of welfare reforms elsewhere and could, therefore, be loosely described as 'evidence-based'. However, as those who are unemployed due to ill health or disability have more complicated barriers to employment (Gardner, 1997), policy mechanisms perceived to have worked in relation to other types of benefit recipients are not necessarily transferable. Nor, given the well-rehearsed warnings about ignoring potentially significant differences between broadly similar contexts (e.g. Marmor, Freeman, & Okma 2005), should it be assumed that evidence relating to welfare reforms in other countries will be applicable to the case of IB reform in the UK. For, although the UK shares some approaches to welfare with countries such as the USA and Australia (Esping-Andersen, 1990), there are also important differences in the welfare provision of these countries (e.g. Bambra, 2005) and significant historical differences in terms of the decommodifying effects of cash benefits and support services for people out of work due to long-term sickness (Stone, 1986; Esping-Andersen, 1990; Bambra, 2005).

In summary, the specific history of IB in the UK implies that the transfer of policy ideas from other contexts is not necessarily appropriate. The relevant (UK based) research which exists does not indicate that the reforms to IB described in this paper will be effective in helping people move from welfare into work. Furthermore, research highlighting the stigma associated with some forms of incapacity claims suggest it will be important to assess the

impact of recent reforms on people's experiences of claiming (or choosing not to claim) particular benefits.

ROLE OF PUBLIC HEALTH

Given the importance of income maintenance during times of ill health, and the links between unemployment and health (Black, 2008), the reforms to long term sickness absence benefits in the UK have potentially important ramifications for public health. No-one would want to deny work to those who want it, and indeed many people in receipt of IB report that they do want to work (Prime Ministers Strategy Unit, 2005). However, it is far from clear, especially given the lack of supporting research evidence, if the current approach to IB reform, characterised by coercion, conditionality and the stigmatisation of certain recipients, is best placed to facilitate return to work or, indeed, the acquisition of suitable (as opposed to any) employment. In fact, echoing analyses of other areas of public policy (e.g. Naughton 2005; Smith, 2007; Stevens 2007), it seems likely that recent IB reforms have been significantly shaped by other factors, such as political priorities and responses to public and media concerns, rather than applicable research evidence.

Part of the problem may be the dearth of research exploring the interactions between ill-health and the experience of receiving welfare benefits. For, whilst there have been a number of studies of the impact of welfare-to-work interventions on employment rates (Bambra et al, 2005), and much is known about the links between unemployment and ill-health (Black, 2008), far less is known about how different kinds of welfare reform impact upon individuals experiencing ill-health or disability who are in receipt of benefits, or how their experiences of different welfare benefits might impact upon their health, well-being and engagement with the formal economy. A new research and practice agenda should therefore be developed, one that critically engages with the politics involved in debates about sickness absence and which places public health concerns at the centre. The experiences of sickness absence recipients need to be incorporated into the theoretical insights that are developed in

such work, which could hopefully serve as an important resource to advocates and policymakers involved in welfare reform.

To begin with, evidence of the efficacy of compulsion on return to work is needed. Hence, evaluations should be undertaken to establish whether making benefit receipt more conditional is actually an effective means of increasing the employment of people out of work due to long term sickness, and whether this works without the instigation of concurrent interventions designed to increase labour demand, improve the accessibility of working environments, and enhance the remuneration received in the entry level jobs typically obtained by people leaving benefits. Such work should be undertaken using a methodological approach which also explores the effects of these reforms (and the associated interventions) on the health and wellbeing of participants (as opposed to merely measuring the employment effects), not least because, for this group in particular, these impacts are likely to be closely related to longer-term prospects for employment. Finally, from a more practice-orientated perspective, community and occupational health practitioners should (re)assert the importance of health within sickness absence debates and feed such concerns into those in charge of commissioning and implementing such interventions so that they prioritise health improvement over (or as a precursor to) return to work.

CONCLUSION

In this article we have outlined the IB reforms and placed them within a historical, theoretical and ideological context. Utilising welfare theory we have argued that recent reforms to IB are a result not of evidence based policy but of a continuing broader political and ideological transformation of the welfare state. In the new politics of welfare, fewer people suffering from ill health or disability will be considered to be 'disabled' and therefore 'deserving' of unconditional state support. Drawing on the work of Stone (1986), Katz (1989) and Bryne (2005), we conclude that in the new politics of the active welfare state, people with a disability or a chronic health condition are no longer considered 'deserving'. In order to fully understand the impacts of these reforms, research exploring the changing experiences of those who claim (or opt not to claim) incapacity related benefits is urgently required. We have

emphasised the need for public health to engage with this issue and have suggested a tentative research agenda in order to better explore the complex relationship between ill health, employment and benefits claims.

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